COVID -19 Questionnaire

Name:_____

Please read each question and circle yes or no. If you have any questions, please let us know.

Yes No	1. Do you have a fever or have you felt hot or feverish recently in the last 14-21 days?
Yes No	2. Are you having shortness of breath or other difficulties breathing?
Yes No	3. Do you have a cough?
Yes No	4. Do you have any other flu-like symptoms such as gastrointestinal upset, headache, or fatigue?
Yes No	5. Have you experienced recent loss of taste or smell?
Yes No	6. Have you been in contact with confirmed COVID-19 positive patients in the last 14 days?
Yes No	7. Do you have heart disease, lung disease, kidney disease, or any autoimmune disorders?

Patient Consent & Signature: **Date:**

X_____ **_____**